National Emergency Medical Services Advisory Council

Virtual Meeting Summary

February 10–11, 2021

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These minutes, submitted pursuant to the Federal Advisory Committee Act, are a summary of discussions that took place during the National Emergency Medical Services Advisory Council (NEMSAC) meeting on February 10–11, 2021. See Appendix A for lists of meeting participants and speakers.

Day 1: February 10, 2021

Call to Order and Introductions

Vincent Robbins, MS, Chair, NEMSAC

Mr. Robbins opened the meeting at 1:00 pm and welcomed NEMSAC members and other participants to the meeting. He asked those in attendance to observe a moment of silence in memory of family members, friends, and particularly colleagues and other first responders who have lost their lives to COVID-19.

Opening Comments

Steven Cliff, PhD, National Highway Traffic Safety Administration (NHTSA)

Dr. Cliff thanked NEMSAC for its continued efforts to elevate EMS and 911 issues at the national level. The council's ideas and combined expertise ensure the continued safety of highways and improve the emergency treatment and transportation of the millions of ill or injured people across the United States and its territories.

For the past 12 years, Dr. Cliff has served in various technical and leadership roles at the California Air Resources Board and the California Department of Transportation. His work has focused on reducing emissions from vehicles and engines and integrating electric vehicles into the nation's vehicle fleet.

Dr. Cliff looked forward to supporting the EMS community and learning more about its lifesaving work. EMS is vital to the health and safety of communities, and its professionals serve the public selflessly every day. EMS providers have been on the front lines of the fight against COVID-19 for almost a year. Too many EMS providers have been lost to this terrible pandemic, and the nation owes them a debt of gratitude. Since the start of the pandemic, 307 law enforcement officers, 105 firefighters, 73 EMS clinicians, and sixteen 911 telecommunicators have died of COVID-19.

During the pandemic, a number of risky driving behaviors have increased, such as not wearing a seat belt, speeding, or driving after using drugs or alcohol. In addition, rates of alcohol and drug use by seriously and fatally injured drivers and passengers rose in 2020, and drivers and passengers who had recently used drugs or alcohol and who were seriously or fatally injured were much less likely to have worn a seat belt than those who had not recently used alcohol or

drugs. These trends make the work of EMS providers both more difficult and more important, and NEMSAC plays a critical role in supporting these providers.

On behalf of the U.S. Department of Transportation, Dr. Cliff thanked departing NEMSAC members for their commitment and their service. NHTSA is reviewing applications for new NEMSAC members. Another priority for the Office of EMS is to update the NEMSAC charter.

Introductions of Members and Disclosures of Conflicts of Interest
Jon Krohmer, MD, Office of EMS, NHTSA

Dr. Krohmer introduced Clary Mole, who recently joined the Office of EMS as an EMS specialist. He helps coordinate the activities of NEMSAC and the Federal Interagency Committee on EMS (FICEMS).

Dr. Krohmer asked NEMSAC members to identify conflicts of interest or potential conflicts of interest that have arisen since the August 18–19, 2020 NEMSAC meeting. NEMSAC members disclosed the following new real, potential, or perceived conflicts of interest:

- Mr. Washko: Chair of the Quality Committee for the National EMS Management Association; advisory board member for organizations involved in telehealth and in 911 and dispatch
- Ms. White: Member, executive board, Prehospital Guidelines Consortium

No other NEMSAC member reported a new or potential conflict of interest.

Dr. Krohmer explained that the NEMSAC committee meetings at this meeting were originally scheduled to be closed to the public. Because questions came up about whether restricting committee meetings to NEMSAC members was permissible under the Federal Advisory Committee Act, NHTSA decided to invite members of the public to attend. However, the NEMSAC committees are subcommittees of an advisory council to the Department of Transportation. As a result, these committee meetings do not need to be announced in the *Federal Register* or open to the public. Furthermore, NEMSAC committees may only report to NEMSAC and not directly to any federal official or agency.

In addition, the Office of EMS will continue to enforce the requirement for NEMSAC committees to submit advisories and other documents to the Office of EMS at least 1 month before each NEMSAC meeting. This requirement is necessary to give NEMSAC members and members of the public time to review these materials.

Approval of August 18–19, 2020, NEMSAC Meeting Minutes

A motion carried to approve the minutes of the August 18–19, 2020, NEMSAC meeting.

NEMSAC Committee Reports

Profession Safety Committee

Mr. Powers reported that one advisory would be presented to NEMSAC for final approval:

- Addressing Patient Elopement During EMS Transport

Integration and Technology Committee

Mr. Kaye reported that this committee was not working on any advisories, but it had identified topics for the next NEMSAC to consider for advisories:

- Ambulance crash investigations (to be carried forward by Mr. Washko, who will serve through 2022, the second year of his second term on NEMSAC)
- Community paramedic dataset
- Standards for 911 training (perhaps in collaboration with the Preparedness and Education Committee)

Preparedness and Education Committee

Ms. Lubogo reported that the committee would present two advisories for final approval:

- Best Practice for Transition from Technical Certificate Paramedic Providers to Practitioners with Formalized Education and Professional License to Practice
- EMS Resource Allocation and Distribution during Disasters

A third advisory would be presented for interim approval:

- Human Trafficking Education for EMS Professionals

A proposed new topic is:

- Certification for EMS instructors

Equitable Patient Care

Dr. Bradley reported that this committee had hoped to present the following advisory for final approval:

- Reducing Social Inequities in EMS Through a National Out-of-Hospital Cardiac Arrest Registry

However, because this advisory had not been sent to NEMSAC before the meeting, it would remain in interim status. The next NEMSAC could consider giving final approval to this advisory.

Two proposed new topics are:

- Social determinants of health
- Impact of COVID-19 on patient care

EMS Sustainability and Efficiency Committee

Mr. Baird said that this committee had no advisories to present for interim or final approval.

Adaptability and Innovation Committee

Mr. Gale said that this committee had no advisories to present for interim or final approval.

Ad Hoc Pediatric Restraints Committee

Ms. Montera reported that this committee had drafted a letter from NEMSAC to the Secretary of Transportation. The letter suggested that the department evaluate the need for testing standards for pediatric transport devices used in ambulances.

Dr. Fallat suggested deleting the reference to a 77-kg adult in the draft letter.

Public Comment on Committee Reports

David Becker, MA, the immediate past chair of the EMS Section for the International Association of Fire Chiefs, opposed the recommendation in the revised advisory on formalized education for NHTSA to develop a program to advocate for the value of academic degree attainment by paramedics. A pathway is already available for every paramedic student to obtain a college degree.

Scott Cormier, a member of the board of the International Association of EMS Chiefs and Vice President of Emergency Management, Environment of Care, and Safety at Mexcel, compared the training issues in EMS with those in nursing. Students can become nurses by completing a certificate program, a 2-year associate degree program, or a 4-year bachelor degree program. Regardless of their training, nurses have similar skills, and a move to require all nurses to obtain a 4-year degree failed. A more stringent education requirement would be a disincentive for entering the EMS field.

Christopher Montera, a paramedic in Florida, argued that the EMS field needs well-educated paramedics who have other skills. Requiring a 4-year degree will help the field advance and be considered part of health care. Such a requirement could also open leadership positions for paramedics and increase reimbursements.

Kelly Russ, MPA, chief of Putnam County, Indiana, EMS, agreed that it is time to require degrees for paramedics. This change could give EMS professionals more public recognition and equitable compensation because they will have the same levels of knowledge as other health care providers. The COVID-19 pandemic has shed a spotlight on EMS, so now is the time to gain the needed recognition and equitable treatment to that of other health care providers. The return on investment in education will be high.

Mr. Robbins explained that NEMSAC issues advisories, which provide recommendations to the Secretary of Transportation and FICEMS. The Office of EMS in NHTSA is then responsible for

reviewing and implementing the recommendations. The advisories do not provide rules or regulations. NHTSA creates standardized educational materials that states can use, but states control the licensure and certification of their EMS practitioners. Neither NHTSA nor NEMSAC has the authority to issue regulations or to impose requirements on states. Therefore, NEMSAC would not require states to change their educational requirements for new EMS providers.

David Fifer, MS, a paramedic and EMS educator in Kentucky, expressed support for the formalized education advisory. He approved of the value proposition described in the advisory for encouraging EMS providers to obtain a 4-year degree. The benefits of this change go beyond increases in reimbursement or whether obtaining an education is a sound financial investment for a new EMS professional. In addition to direct patient care, EMS requires familiarity with public safety, general wellness, health information, technology, finances, and social determinants of health. The certificate model does not necessarily prepare the EMS workforce for all requirements of the field. Cost is the greatest challenge to making this change, but the amount needed is small. Every paramedic can claim some credits for the training they received for certification, and the cost of the additional credits they require is small.

Mike Touchstone, Deputy Chief of EMS Operations in the Philadelphia Fire Department, agreed with Mr. Fifer's arguments. Broader and deeper education will prepare paramedics for other roles, including in education, supervision, and management. Many people who are promoted to these positions do not have appropriate preparation.

Mr. Garrett said that recommendations to require 4-year degrees for EMS providers have sent shockwaves to those who work in the field. EMS providers do their jobs regardless of whether they have a 4-year degree, even though they do not receive the additional reimbursement that accompanies a degree. Most states cannot afford to hire providers with a degree. The number of students entering EMS training programs has dropped, partly because of the dangers of this profession during the COVID-19 pandemic. Many people who are making decisions about degree requirements have not worked in the field in years, so they do not understand the concerns.

Mr. Baird suggested that the paragraph under the second recommendation in the formalized education advisory broaden the list of potential members of the stakeholder group to include private EMS agencies and make clear that this list is not all inclusive.

Dan Gerard, President Elect of the International Association of EMS Chiefs, agreed that EMS providers who do not have a degree should not feel inferior to colleagues who have one. Decisions about education need to be based on the needs of the future and how best to meet those needs. Education that leads to degree is probably the best way to prepare providers for their future roles.

FICEMS Strategic Plan Update

Marc Sigrist, Analyst, Energetics

FICEMS will soon receive its draft 2021–2025 strategic plan to review. The six updated strategic goals in the plan align with the purposes in the legislation that established FICEMS and with

EMS Agenda 2050 guiding principles. Once FICEMS feedback is received, the strategic plan will be finalized and published on EMS.gov.

Dr. Krohmer invited NEMSAC members to share feedback on the strategic plan content in Mr. Sigrist's presentation with the Office of EMS within the next few days.

Emergency Triage, Treat and Transport (ET3) Model

Janelle Gingold, MPH, Center for Medicare & Medicaid Innovation, Center for Medicare & Medicaid Services (CMS)

CMS is using the ET3 model to test a new reimbursement mechanism for ambulance suppliers and providers to transport Medicare beneficiaries to a broader range of destinations than those typically covered. Because of the ongoing public health emergency, CMS has temporarily expanded the range of destinations to which beneficiaries can be transported, and the ET3 model has been revised to take advantage of this temporary flexibility.

The ET3 model is testing three main interventions:

- Fee-for-service payment for transporting Medicare beneficiaries to an alternative destination
- Fee-for-service payment for facilitating and initiating treatment in place by a qualified health care provider on the scene or by telehealth
- Establishment or expansion of medical triage lines staffed by health care professionals who refer eligible callers to alternative sources of care

On January 1, 2021, CMS launched the two initial components of this model, and the agency will soon release a notice of funding opportunity for the medical triage line component. Model participants will be encouraged to form relationships with these entities.

CMS initially chose 205 Medicare-enrolled ambulance suppliers and providers or hospital-based ambulance providers as model participants. More than 170 of these agencies agreed to participate in the model after its launch was delayed by the COVID-19 pandemic. Each participant must establish a partnership with at least one alternative destination site (e.g., clinics, behavioral centers, and urgent care centers). Partnerships with qualified health care providers of treatment in place in person or through telehealth are optional. CMS also encourages participants to form relationships with non-Medicare payers to provide reimbursement for ET3 Model services. By Year 3, the program will offer 5% bonuses for achievement of key quality measures that are being developed now. CMS will also give participants opportunities to share best practices with one another and receive support when needed.

Body Cameras in EMS

Ryan Stark, JD, Page, Wolfberg, & Wirth, LLC

Many of the legal issues associated with the use of body cameras by EMS agencies involve local legislation, so agencies considering their use should consult a local attorney.

Body cameras record interactions between the provider and the patient, and the resulting video files include audio recordings. They can capture close images of patients as well as sensitive patient information and actions in the field and inside ambulances. Body cameras therefore capture protected health information as defined by the Health Information Portability and Accountability Act (HIPAA). These files thus require the same protections under HIPAA as written protected health information.

EMS agencies can use body camera recordings for quality assurance and quality improvement. These recordings are also useful for changing behaviors (of providers, patients, and the public), catching issues that need to be addressed, and responding to complaints. Finally, recordings can provide legal protection when, for example, a patient behaves aggressively.

HIPAA permits the use of videos and images for treatment and health care operations, including quality assurance and quality improvement. However, EMS agencies must secure the recordings and use them only in accordance with the purposes permitted by HIPAA. For example, the recorded data must be encrypted when it is stored, transmitted, or used. Agencies should require providers to download their recordings as soon as possible (e.g., at the end of each shift). Agencies that use body cameras must sign business associate agreements with vendors that store recording.

State laws govern requirements for invasions of privacy and consent. Ways to satisfy the requirements might include lowering patient expectations of privacy by posting signs stating that recordings are in progress or that the provider's body camera is recording the patient. Many agencies allow providers to turn body cameras off if patients do not want to be recorded.

EMS agencies in states with one-party wiretapping laws do not need the patient's consent to record them, but those in two-party states need consent from all parties. Agencies must also abide by public disclosure laws when deciding how long to store recordings. The longer recordings are kept, the longer they are subject to public disclosure requirements, the greater the cost, and the greater the concern about breaches.

Discussion

Eric Chaney, EMS Specialist in the Office of EMS, reported that an agreement with Mr. Stark is being developed to create a document on use of body cameras by EMS agencies.

Ms. Lubogo asked whether public education provided by EMS agencies on body camera use includes information on patient rights. Mr. Stark replied that many agencies do inform patients of their rights, and providers typically ask whether they may record patients. However, agencies need to develop policies on these interactions, and providers should not be responsible for deciding whether to a record a patient.

Recognizing and Protecting Sexual Trafficking Victims

Mary Fallat, M.D., University of Louisville; Member, NEMSAC

According to federal law, sexual trafficking is recruiting, harboring, transporting, providing, or obtaining a commercial sex act that is induced by force, fraud, or coercion. On average, the age of entry into sexual trafficking is 12 to 14 years. Runaways are the most common victims of sexual trafficking, and 90% turn to the sex trade if they are away from home for more than 3 months. Young people are recruited by sexual trafficking by force (e.g., starvation, rape, drugs, or physical or sexual abuse), fraud (e.g., false romantic relationships, lies, or deceitful employment promises), or coercion (e.g., threats of deportation or blackmail).

Dr. Fallat distinguished between three types of pimps. The gorilla pimp uses force to overpower the victim, is ostentatious, and carries a great deal of cash. The Romeo pimp uses charm, gifts, and flattery to recruit girls seeking love and acceptance and runaways. The CEO pimp uses money and business strategies to swindle aspiring models and entertainers. Types of sexual trafficking include forced prostitution, stripping, and pornography. Victims can be recruited on streets, in brothels and homeless shelters, and at truck stops and strip clubs.

Sexual trafficking victims need medical evaluation for acute injuries related to violence, sexually transmitted or other infections, exacerbations of poorly controlled chronic diseases, drug intoxication or withdrawal, and reproductive issues. Some might need evaluation after an assault.

Signs of sexual trafficking in young people can include:

- Fear of making eye contact
- Attitude of shame
- Attempt to act older than they seem to be
- Appearance of being denied food, water, or sleep

Victims might seem to be lying when they answer questions, carry false or several identification cards, or be accompanied by an overly controlling "boyfriend" or "family member" who does not match the victim's age or ethnicity. Psychological signs of trafficking can include posttraumatic stress disorder symptoms, chronic fear or anxiety, memory loss, somatic complaints, aggression or violence, guilt, hopelessness, and substance abuse. Victims might have signs of physical abuse, inadequate or delayed medical care, multiple sexually transmitted infections or pregnancies, urinary tract infections, vaginal bleeding, difficulty urinating, pelvic pain, rectal trauma, or branding tattoos.

Most human trafficking survivors have some contact with the health care system while they are being exploited. Therefore, EMS and other health care providers often have opportunities to recognize that something is wrong and provide support. EMS providers can ask certain screening questions, such as "Where are you living now?" or "Is anyone forcing you to do anything you do not want to do?" If any health care worker or employee suspects sexual trafficking, they must inform the victim's health care team, which then alerts the appropriate individuals in a nonthreatening and nonsuspicious manner.

The Polaris Project has resources on how to recognize human trafficking. The National Human

Trafficking Resource Hotline (1-888-373-7888) and National Runaway Hotline (1-800-RUNAWAY) can also provide assistance.

EMS and Public Health Emergencies

Jon Krohmer, MD, Office of EMS, NHTSA

The largest public health emergency of our generation, the COVID-19 pandemic, has clearly demonstrated the need to include EMS in the public health safety net. For example, training is being provided to emergency medical technicians (EMTs) to administer COVID-19 vaccines. Dr. Krohmer asked NEMSAC to discuss the role of EMS in public health.

Mr. Washko pointed out that EMS providers are witnessing the impact of the social determinants of health every day. They know their communities and what resources they need, which are public health issues. EMS can also contribute to public health through the National EMS Information System (NEMSIS) and other 911 datasets. Mr. Powers agreed. Paramedics and EMTs are excited about the opportunity to support mass vaccination clinics. Mr. Robbins commented that EMS has been involved in public health for some time. Examples include instructing the public on the use of car seats and prevention of drowning in pools. During the pandemic, EMS agencies have been taking on new public health roles.

Public Comment

Amanda Perry, MEd, the Louisiana EMS for Children program manager, thanked NEMSAC for its promotion of the safe transport of children in ambulances. She also thanked Dr. Fallat for her discussion of human trafficking. Louisiana is pilot testing a human trafficking training program for EMS professionals.

Day 2: February 11, 2021

EMS Compact

Joe Schmider, Interstate Commission for EMS Personnel Practice
Dia Gainor, National Association of State EMS Officials (NASEMSO)
Ray Mollers, National Registry of Emergency Medical Technicians
Dan Manz, Interstate Commission for EMS Personnel Practice
Donnie Woodyard, MA, Colorado Department of Public Health and Environment

Mr. Schmider explained that 22 states have enacted legislation that supports the EMS Compact, which became operational in April 2020.

Ms. Gainor stated that when state EMS offices look up an EMS provider online, all they can learn is whether that individual is or is not licensed, and not whether that individual has been licensed in the past or, more importantly, whether any administrative action (e.g., revocation or suspension of a license) has been taken on a provider's licensure or privilege to practice.

Some states publish reports of final administrative actions, and others send this information, and perhaps the reason for the suspension or revocation of a license (e.g., felony conviction or providing EMS interventions while intoxicated), to other states in response to queries.

An applicant might not list all the states in which they have been licensed. As a result, a state might not send queries to all applicable states and thus might not learn that the provider's license was subject to an administrative action in another state. States may not share with other states significant investigatory findings about EMS personnel, especially while these investigations are in progress or when no final administrative action was taken. Although the National Practitioner Data Bank provides some of this information, not all states submit their information, and this database only lists final administrative actions.

Mr. Mollers explained that the National Registry of EMTs is the nation's EMS certification body and has a database of all certified EMS Practitioners. In every state, national EMS certification is a pathway to initial state EMS licensure. The National Registry makes available certification status for current and expired nationally registered providers, but it does not track state licensure status. Therefore, if a state revokes a provider's state EMS license, this information is not automatically reported to the National Registry.

The National Registry established the National EMS Coordinated Database (NEMSCD) to share information on state licensure, National Registry certification, and EMS Compact privilege to practice of EMS personnel in Compact member states. To connect a state's licensure information to NEMSCD, the National Registry system must validate or create a national EMS identification (ID) number for each licensed provider in the state.

Mr. Manz explained that the EMS Compact model legislation reads "The coordinated database administrator shall promptly notify all member states of any adverse action taken against, or significant investigative information on, any individual in a member state." Whenever a state updates information about adverse actions or significant investigations, the NEMSCD triggers an automatic message to the other Compact states. The cross-border privilege to practice was launched in the spring of 2020 and has helped bring additional EMS providers to assist with COVID-19 operations when needed.

The NEMSCD had information on:

- EMS provider ID and licensure from all states in which that individual is licensed
- Adverse actions
- Restrictions on licenses
- Denials of licenses
- Significant investigations

Each year, a few more states join the EMS Compact, and the goal is to add all 50 states. The main barriers to entry are the challenge of introducing Compact legislation when state leaders have other priorities, the belief among state leaders that participating in the Compact is more expensive than it really is, and the lack of a requirement for fingerprint background checks.

Mr. Woodyard reported that Colorado is now using the NEMSCD, and it appreciates the ability to look up the licensure status of EMS providers in other states. In 2020, when Colorado experienced devastating wildfires during the COVID-19 pandemic, the state used personnel from many other states through the Compact to supplement its licensed EMS personnel without compromising the state's ability to protect the public, EMS providers, or system integrity.

Discussion

Mr. Robbins asked about activities to recruit more states into the EMS Compact. Mr. Manz said that such activities are underway. Most states that have not yet joined would like to do so, but many do not require fingerprint background checks because of the cost ($30 to $50 per background check).

NEMSAC Appointment Terms

Dr. Krohmer asked NEMSAC members completing their first term who not already done so to send a letter to the Office of EMS as soon as possible indicating their interest in remaining on the council for a second term. The office extended the submission deadline because it did not receive enough applications for some NEMSAC openings, but it has since received applications for all open seats. A team will review the applications and send a list of recommended candidates to the Secretary of Transportation for final review and approval. Dr. Krohmer hoped that the process would be complete within 2 months.

Mr. Robbins suggested that the current NEMSAC continue to work on its advisories or even reconvene if new members are not appointed soon. Dr. Krohmer agreed with this plan, and Mr. Robbins will inform the committee chairs that they may continue to work on their advisories.

Workforce Development: Diversity and Inclusion

Sydney Puricelli, JD

Ms. Puricelli, a labor and employment attorney who was second deputy commissioner for the Detroit Fire Department, reported that when a class of 25 cadets would join her fire department, all members would be white men even though Detroit is majority Black. The reasons for this lack of diversity are systemic and include lack of education, of funding to obtain an education, and of familiarity with EMS as a career path among underserved populations. But EMS agencies cannot effectively serve diverse communities using a single language, world perspective, or appearance.

Leaders of EMS agencies and departments need to invest in including disadvantaged people in their workplaces. These leaders often say that they want to do better, but they do not demonstrate commitment to do so. Simply including one or two women or minority individuals in a class or following existing policies will not solve the systemic problem. Discrimination laws do not tell employers how to create a more inclusive working environment.

Ms. Puricelli recommended the following approaches to address challenges to making workplaces more inclusive and diverse:

- Before hiring: Start recruiting candidates at younger ages, provide pathways to obtain EMT training that do not involve 4-year college degrees, offer scholarships for training, and change recruitment approaches
- During training (as soon as a provider starts work at an agency): Discuss the importance of empathy and open-mindedness, be honest about implicit bias, focus on customer service, and treat patients and colleagues with empathy and respect
- Maintenance of diversity: Create a culture that emphasizes being kind, genuine, and transparent; ensure that all conversations make those involved feel positive about their contributions and values in the workplace; and make sure that everyone in the workplace feels safe from discrimination, harassment, or devaluation as a human being at work

Many women continue to feel belittled and harassed throughout their careers, and EMS is still dominated by men. Agency leaders must not turn a blind eye to gender and sexual harassment. They must stop men, especially superiors, from demeaning women (e.g., by telling them that they look pretty). Women must be made to feel welcome.

The benefits of diversity and inclusion include bringing in new ideas and different perspectives, finding different ways to grow the agency, and establishing different types of relationships with hospitals and communities. This approach will expand the talent pool immediately.

Discussion

Ms. Lubogo said that NEMSAC has recruited several women, but it needs to do more to recruit members of underrepresented populations. She hoped that the new NEMSAC will be more diverse than the current group.

EMS Response to Civil Unrest

Denis FitzGerald, MD, Office of the Assistant Secretary for Preparedness and Response, Department of Health and Human Services

Denis Fitzgerald reported that the risk to first responders, including EMS personnel, from civil unrest events is increasing. At any large social gathering, all the factors necessary for violence exist, and the only question is whether these factors will interact with the volatile chemistry needed to precipitate a riot. Events that can trigger civil disturbance include a judicial verdict, political event, social cause, or sports event. Groups foster an environment that lowers individual inhibition because of a collective sense of anonymity, a diffusion of personal responsibility, a strong social urge to conform with the group, and a loss of individual decision making. Persons and groups can become more susceptible to suggestion, manipulation, and imitation by strong leaders. A group's emotional volatility is a powerful motivating force.

Some crowd members are very committed to the cause, and others are caught up in the frenzied periphery of the event. When the circumstances are right and the right factors interact with one another, a critical transition can occur in any group that can precipitate violence, including large-scale rioting. As group cohesion evolves, the crowd becomes its own organism, with a collective identity, purpose, emotional tone, focus, and coordinated response. Members are more prone to

participate in activities that they would not do if they were alone. If the group's tone shifts toward anger or frustration, violence can erupt.

EMS providers must respect the potential of any crowd to become a mob capable of violence. They should be ready to respond to chemical exposures of all kinds by, for example wearing protective eyewear and being ready to use eye irrigation to treat eye injuries. Traumatic injuries can occur from physical blows and sharp objects, so good trauma protocols and equipment are necessary. Fireworks and Molotov cocktails can be launched during civil unrest; therefore, burn injuries can occur. Mass casualty care might be required, such as when a vehicle rolls into a crowd, a crowd surges into a small area, or an active shooter is present.

Ensuring EMS provider safety requires planning for preventing or responding to problems in EMS responses or staging at any large gathering. A medical threat assessment or incident action plan is key. EMS agencies need to coordinate their activities with law enforcement and fire agencies in advance so that providers can deliver care safely to those who need it. Agencies should also review procedures for EMS care and evidence collection to protect EMS providers if legal questions arise.

During an incident, personnel accountability is critical. Agencies might, for example, use deployment tracking technology to make sure that personnel are safe and can be located if their assistance is needed. Situational awareness for EMS providers can include identifying areas that might be safe or dangerous, mentally rehearsing what-if situations, and paying attention to external sources of information (including radio announcements and social media posts) as early indicators of trouble. Other issues include personal protective equipment, vehicle positioning, colocation with law enforcement personnel, and awareness of zones of care (hot, warn, and cold). After an incident, agencies should engage in crisis communications and provide supportive care for personnel injuries and behavioral support for critical incident stress.

Training is available through the Counter Narcotics and Terrorism Operational Medical Support Program of the Department of Health and Human Services and the U.S. Park Police.

Discussion

Mr. Robbins commented that some agencies have issued body armor to EMS personnel or allowed them to carry personal weapons, including firearms. He wondered whether such policies make EMS personnel feel safer or more anxious. Dr. FitzGerald replied that factors that influence responses to these policies include whether the EMS agency will be responsible for providing armed capability or will work with law enforcement and fire agencies. Training and policies are critical for people who will wear body armor or carry a weapon. Each jurisdiction must decide whether to take on these responsibilities or find ways to address these needs in partnership with public safety agencies.

Dr. Krohmer asked how citizen EMS teams can obtain enough information about a situation or event to keep themselves safe and whether they can count on law enforcement personnel to support them during events. Dr. FitzGerald replied that such discussions need to occur before each event. Law enforcement agencies can share information with partner public safety agencies

about public events, such as demonstrations with potential for civil unrest. Each agency brings a critical toolkit, and agencies can be more effective if they work together.

Public Comment

Mr. McClintock, Deputy Director, International Association of Firefighters, thanked the Preparedness and Education Committee for accepting the association's comments on its formalized education advisory. He was still concerned about the use of the word "mandate" in this advisory, and 2025 is an aggressive deadline for the activities in the document. Ms. Lubogo expressed appreciation for the input that the committee has received from many members of the public, and she thanked the committee members for all of their hard work on this advisory.

Kelly Bouthillet, DNP, an acute care nurse practitioner and clinical nurse specialist at Hilton Head Island Fire/Rescue, submitted the following written public comment:

> Today's nurses and health care clinicians, including paramedics, are burdened with more responsibility while working with less resources [and] require more knowledge and sharp problem-solving skills in careers that demand high levels of professionalism simultaneously with compassion. It is no longer "nice to know" but necessary for nurses and other health care professionals to seek out new learning opportunities and experiences to apply knowledge in meaningful ways that lead improved advanced clinical practice and patient care outcomes. Literature and quality metrics have indicated a direct link between level of education and patient trajectories and outcomes (AACN, 2019). Professional nursing organizations endorse professional development through [achievement of] academic degrees and ongoing knowledge acquisition. Promoting achievement in education [is] necessary to ensure minimum standards for entry into practice as well safe patient outcomes.

Attached to Dr. Bouthillet's remarks was a fact sheet, The Impact of Education on Nursing Practice, from the American Association of Colleges of Nursing.

Mark Irvine, Secretary of the Emergency Medical Services Labor Alliance, read aloud the following written remarks:

> My name is Mark Irvine, and I am the Secretary of the [Boston Police Patrolmen's Association], the union for the 400 proud EMTs and paramedics of Boston EMS. I write on behalf of the Emergency Medical Services Labor Alliance (EMSLA), whose 20,000 members provide EMS services to … Boston; New York; Pittsburgh; Cleveland; New Castle County, Delaware; Austin-Travis [County, Texas]; Sacramento; and other [cities and counties].
>
> I write to request that the National EMS Advisory Council (NEMSAC) seek an amendment to its charter for a sector position on the council representing EMS labor organizations. The voice of a representative of EMS labor organizations would strengthen the diversity of viewpoints available to the NEMSAC, which will enhance the council's ability to fulfill its purpose to serve "as a forum for the development, consideration, and

communication of information from a knowledgeable, independent perspective" to NHTSA and FICEMS.

NEMSAC's charter properly sought to create a diverse board to ensure input from all relevant sectors of the EMS Community. The charter states, "the Council's broad-based membership will ensure that it has sufficient EMS system expertise and geographic and demographic diversity to accurately reflect the EMS community as a whole." To that end, the charter delineates 25 EMS sectors covering the broad range of voices of the EMS community. However, the 25 current sectors do not provide for the input from the worker representatives of the tens of thousands of EMTs and paramedics providing first responder services. EMSLA would bring a vital, currently unrepresented voice to NEMSAC.

The member groups of EMSLA speak for their boots-on-the-ground members responding to the nation's 911 calls every day. Our members are truly in the trenches providing the first contact to the public in providing emergency medical services. Whether it be dealing with street violence, responding to emerging trends in substance abuse, confronting the escalating epidemic of undertreated mental problems, or dealing with the current global pandemic, our members are at the very front of the front line of health care. Our voices represent a unique perspective [on] the reality of the delivery of EMS services.

To date, EMSLA members have worked with NEMSAC [by] working with committees and contributing to the crucial work of the council. But there is currently no seat for EMS labor on the council itself. We believe that the voice of workers is an essential one so that the "EMS community as a whole" is represented on NEMSAC. The inclusion of EMS labor as an official sector, thereby allowing … a EMS labor seat on the council, would improve the council and would allow it to better [perform] its duties.

For all these reasons, I write to request that NEMSAC seek to amend its charter to add EMS labor as a sector for inclusion on the council.

On behalf of EMSLA, I thank you and NEMSAC for your consideration of this request. The members of EMSLA are proud to work every day to provide the highest level of EMS services to the residents of our great country. We would be honored to be able to share the insights we have learned in order to enhance the good work of NEMSAC. Please do not hesitate to contact me with any questions or to discuss. Thank you again.

Mr. Robbins said that NEMSAC will share Mr. Irvine's remarks with NHTSA, which responds to requests for modifications to the NEMSAC charter. He pointed out that the NEMSAC seats are not assigned to given associations. For example, although the charter lists emergency physicians as one of the membership categories, it does not reserve this seat for a representative of a specified association. NEMSAC does have a seat for an EMS practitioner, although the charter does not specify that this individual must represent a given EMS union. Mr. O'Neal added that if the charter is amended to include an EMS labor representative, it should add a total of two new members to make the total number of NEMSAC members 27 and avoid impasses from tied votes.

Committee Reports

Mr. Robbins reminded NEMSAC that NHTSA staff review all advisories to determine the feasibility of each recommendation. In some cases, staff suggest modifications to NEMSAC.

Profession Safety Committee

Addressing Patient Elopement during EMS Transport

A motion carried to grant final approval to this advisory after Recommendation 1 is split into two recommendations.

Preparedness and Education Committee

Human Trafficking Education for EMS Professionals

Dr. Krohmer clarified that the scope of the National EMS Education Standards does not include all items listed in Recommendation 2. The standards could list human trafficking as a topic to include in EMS education, but implementing this recommendation would be the responsibility of developers of curricula and training materials. The Office of EMS can clarify this distinction in the recommendation.

Other organizations in addition to the National Emergency Number Association should probably be involved in implementing Recommendation 3. Dr. Krohmer therefore proposed changing the sentence in question to "using the standard operating protocols of the National Emergency Number Association and other appropriate professional organizations…."

Dr. Krohmer asked whether the committee had verified that the type of study suggested in Recommendation 4 has not been conducted. Dr. Adelgais replied that she had searched for but did not find such studies. Virtually no research has been conducted even on EMS and child maltreatment in general.

A motion carried to grant interim approval to this advisory.

EMS Resource Allocation and Distribution During Disasters

For Recommendation 4, Dr. Krohmer commented that in addition to NEMSIS, the Office of EMS developed a tool for EMS agencies to report on personal protective equipment, staffing, and other needs related to COVID-19. Several states have developed their own mechanisms for reporting this information, and the Office of EMS is working with them to bring all this information together. Some EMS agencies view this type of reporting as burdensome, even though responding to a few questions takes less than 5 minutes. Therefore, implementing such a system across the country would be challenging.

Dr. Krohmer asked whether Recommendation 5 refers to bringing guidance and resources that pertain to EMS into a repository or to creating a synopsis of this information. Mr. Robbins replied that the recommendations is for NHTSA to collect this information, ensure that materials from different agencies do not conflict with one another, and summarize the content. Dr. Krohmer said that this recommendation should be discussed by FICEMS. Because different federal agencies have different missions, their guidance will always include some conflicts. These conflicts are a reason the EMS/Prehospital Team of the Federal Healthcare Resilience Task Force generated EMS-specific documents.

A motion carried to grant final approval to this advisory.

Best Practice for Transition from Technical Certificate Paramedic Providers to Practitioners with Formalized Education and Professional License to Practice

Mr. O'Neal explained that Kansas requires EMS providers to be able to have a degree as a component of successful course completion, but this degree is not a state requirement for licensure or practice, and this requirement only applies to those who take courses in Kansas. For this reason, he suggested deleting references to Kansas in the advisory.

Ms. Montera pointed out that the version of the advisory that NEMSAC members were reviewing during this meeting was not up to date. Dr. Krohmer explained that the committee could not vote to approve an advisory that it could not look at. Mr. Robbins therefore proposed modifying the document that NEMSAC was viewing to include the most recent changes. Dr. Krohmer said that this suggestion was acceptable, and the document that the Council was viewing was edited accordingly.

Dr. Krohmer said that legal council would be needed on the first recommendation because NEMSAC might not have the authority to write a white paper. Mr. Robbins pointed out that NEMSAC has issued position statements in the past, so he suggested replacing "white paper" in Recommendation 1 with "position statement." Dr. Krohmer agreed with this suggestion.

Dr. Krohmer asked about the purpose of the survey proposed in Recommendation 1. Mr. Robbins explained that the survey would collect feedback on a potential requirement for EMS practitioners to obtain a college degree. Dr. Krohmer said that such a survey would be challenging to conduct because of Office of Management and Budget rules regarding surveys.

A change suggested by Dr. Krohmer was to replace the word "advocate" in Recommendation 3 because NHTSA is not permitted to advocate. Mr. Robbins said that this statement will be changed to "to educate the industry on the value of …."

Mr. Robbins said that the statement regarding the academic affiliation requirement of the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP) is true for all paramedic education programs seeking for CAAHEP (Commission on Accreditation of Allied Health Education Programs) accreditation nation-wide. Mr. O'Neal agreed but added that Kansas chose to list this requirement in its regulations.

A motion carried to strike all mentions of Kansas from the advisory.

NEMSAC reviewed the use of the word "mandate" in the advisory and concluded that the document does not suggest a mandate for a college degree.

Mr. Washko suggested extending the target date of 2025 for Recommendations 2 and 3 because of the amount of work involved and the need for NHTSA to find funding for these activities. A motion carried to amend the target dates for Recommendations 2 and 3 to 2030 by roll call vote (see vote results in Table 1).

	Yes	No	Abstain	Did Not Vote
Kathleen Adelgais	X			
Mary Ahlers	X			
Shawn Baird	X			
Cherie Bartram	X			
Richard Bradley	X			
Eric Emery		X		
Mary Fallat	X			
Val Gale	X			
Brett Garett				X
Sean Kaye	X			
Lori Knight	X			
Nanfi Lubogo			X	
William McMichael		X		
Anne Montera	X			
Chuck O'Neal		X		
Matthew Powers		X		
Vincent Robbins				X
Peter Taillac		X		
Jonathan Washko	X			
Lynn White		X		
Totals	**11**	**6**	**1**	**2**

Table 1. Roll Call Vote on Change in Target Date from 2025 to 2030 for Recommendations 2 and 3 in Advisory on Formalized Education

A motion carried to call the question of the motion to grant final approval to this advisory. The motion to grant final approval to this advisory carried (see Table 2 for voting results).

	Yes	No	Abstain	Did Not Vote
Kathleen Adelgais	X			
Mary Ahlers	X			
Shawn Baird		X		
Cherie Bartram	X			
Richard Bradley		X		
Eric Emery		X		
Mary Fallat	X			

Val Gale		X		
Brett Garett				X
Sean Kaye	X			
Lori Knight	X			
Nanfi Lubogo	X			
William McMichael		X		
Anne Montera	X			
Chuck O'Neal		X		
Matthew Powers		X		
Vincent Robbins				X
Peter Taillac	X			
Jonathan Washko	X			
Lynn White		X		
Totals	**10**	**8**	**0**	**2**

Table 2. Roll Call Vote on Final Approval of Advisory on Formalized Education

Ad Hoc Pediatric Restraints Committee

Ms. Montera asked NEMSAC to review the draft letter to the Secretary of Transportation from NEMSAC on the safe transport of children in ambulances. This letter asks the Department, including NHTSA and FICEMS, to evaluate the need for testing standards for pediatric and pediatric transport devices. Mr. Robbins reminded NEMSAC that this letter was developed in response to a request from NASEMSO, and this letter is not an advisory.

Dr. Taillac agreed that state EMS offices that regulate and license ambulances need standards for pediatric devices used in these vehicles. He suggested that the letter request funding for crash testing to develop standards as soon as possible. Mr. Robbins explained that NEMSAC may not express opinions on amounts of money to spend or sources of funding, and it may not lobby Congress. NEMSAC makes broad recommendations, and NHTSA has broad discretion in implementing these recommendations. Dr. Krohmer explained that for these reasons, NEMSAC could not issue the recommendations proposed by Dr. Taillac.

Dr. Adelgais pointed out that community education will be important in addition to standards for testing pediatric transport devices. Ambulances often transport children sitting on a mother's lap, which is unsafe and is not allowed in cars.

Dr. Krohmer asked for clarification on the last sentence of the letter, which says that NEMSAC will provide the Department and FICEMS with more recommendations in the upcoming year. Ms. Montera explained that this sentence has been used in previous letters to the Secretary, and it refers to NEMSAC advisories in general.

A motion carried to approve the draft letter.

Equitable Patient Care Committee

Reducing Social Inequities in EMS Through a National Out-of-Hospital Cardiac Arrest Registry

Because this advisory was not distributed to NEMSAC by the deadline, NEMSAC took no action on it.

Suggested Advisory Topics for Future NEMSAC

See Appendix B for a list of potential advisory topics for the next NEMSAC to consider. These topics were suggested at meetings of the NEMSAC committees.

Mr. Washko suggested as an additional topic EMS leadership competency in making the cultural changes needed to ensure diversity and inclusion in the EMS workforce. Such changes need to start at the top, and leaders need education to create initiatives that can make a difference. Mr. Robbins said that this topic might be appropriate for the Preparedness and Education Committee, but the next NEMSAC will decide whether to address this topic and, if so, which committee should take it on.

Dr. Krohmer commented that several of the potential topics are already being addressed, and he proposed a briefing for NEMSAC on these issues. In addition, some of the topics are more appropriate for the EMS community than for a federal advisory. But in general, the list is strong, and the Office of EMS will share it with the new NEMSAC.

Statements from Retiring NEMSAC Members

Ms. Montera pointed out the enormous amount of work that NEMSAC had accomplished since those completing their second terms had joined the Council. She thanked Mr. Robbins for his leadership as NEMSAC chair since 2017, including his guidance on finalizing some controversial advisories.

Mr. Robbins described his fellow NEMSAC members as consummate professionals who had offered many excellent contributions to the Council's discussions. He added that Dr. Krohmer has been an outstanding director of the Office of EMS and has served as a mentor to Mr. Robbins and the rest of the Council.

Dr. Krohmer thanked Mr. Robbins on behalf of the Office of EMS staff for running excellent meetings and following appropriate procedures throughout. Dr. Krohmer also thanked the other departing NEMSAC members for their hard work. This council has been prolific, and its advisories have been well researched and well written.

Other departing members thanked Dr. Krohmer, the NHTSA staff, and their fellow council members for their work on many important topics. They said that serving on NEMSAC had been a great honor and a great experience.

Adjournment

A motion carried to adjourn the meeting at 4:51 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

_____

Vince Robbins, Chair, NEMSAC Date

These minutes will be considered formally for approval by the council at its next meeting. Any corrections or insertions will be made in the minutes at that time.

Appendix A: Council Members and Speakers

National Emergency Medical Services Advisory Council Members in Attendance and Their Sectors

Kathleen Adelgais, MD, MPH/MSPH
Pediatric Emergency Physicians
Golden, CO

Mary Ahlers, Med, BSN
EMS Educators
Cincinnati, OH

Shawn Baird, MA
Private EMS
Portland, OR

Cherie Bartram
Call Taker/Dispatchers
Richmond, MI

Richard Bradley, MD
Emergency Physicians
Houston, TX

Eric Emery
Tribal EMS
Rosebud, SD

Mary Fallat, MD
Trauma Surgeons
Louisville, KY

Val Gale, MS
Local EMS Service Directors/Administrators
Gilbert, AZ

Brett Garett
EMS Practitioners
McCalla, AL

Sean Kaye
EMS Data Managers
Chapel Hill, NC

Lori Knight RN
Emergency Management
Placentia, CA

Nanfi Lubogo
Consumers
Cromwell, CT

William McMichael, III
Volunteer EMS
Delaware City, DE

Anne Montera
Public Health
Gypsum, CO

Chuck O'Neal
State EMS Directors
Berea, KY

Matthew Powers, RN
Emergency Nurses
Pleasant Hill, CA

Vincent Robbins, MS
Hospital-Based EMS
Neptune, NJ

Peter Taillac MD
EMS Medical Directors
Salt Lake City, UT

Jonathan Washko, MBS
EMS Quality Improvement
Northport, NY

Lynn White, MS
EMS Researchers
Copley, OH

Speakers

Steven Cliff, Ph.D.
Senior Advisor
National Hightway Traffic Safety Administration, Department of Transportation

Mary E. Fallat, M.D.
Professor of Surgery
University of Louisville School of Medicine
Medical Director, Surgical Quality
Norton Children's Hospital

Denis FitzGerald, MD
Division Director, Tactical Programs
Office of Emergency Management
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health & Human Services

Dia Gainor
Executive Director
National Association of State EMS Officials

Janelle Gingold, MPH
Director, Division of Health Innovation and Integration
Center for Medicare & Medicaid Innovation, Center for Medicare & Medicaid Services

Jon Krohmer, MD
Office of EMS, National Highway Safety Administration, Department of Transportation

Dan Manz
Compact Educator
Interstate Commission for EMS Personnel Practice

Ray Mollers
Director of Stakeholder Partnerships
National Registry of Emergency Medical Technicians

Sydney Puricelli, JD
Director, Colleague and Labor Relations
Tinity Health

Joe Schmider
State EMS Director
Texas Department of State Health Services

Marc Sigrist
Analyst
Energetics

Ryan Stark, JD
Managing Partner
Page, Wolfberg, & Wirth, LLC

Donnie Woodyard, Jr., MA
Branch Chief
EMS and Trauma Services
Colorado Department of Public Health and the Environment

Appendix B: Recommendations for Future NEMSAC Advisories

The members of the outgoing NEMSAC (2018-2021) believe it is important to identify EMS-related issues to be considered by the newly appointed NEMSAC members that will join in 2021. In many cases, they are topics the out-going NEMSAC members were unable to address but nevertheless believe are important. Therefore, the out-going NEMSAC members respectfully presents the following topics:

Information & Technology: (Sean Kaye & Cherie Bartram)

1) Ambulance crash data collection and analysis. Review and improved integration of the NHTSA's crash investigation group into ambulance crashes
2) PSAPs transfer of incoming calls to Telemedicine Providers
3) Patient medical data transfer during calls, in real time, to receiving healthcare facilities.
4) Integration of caller's smart phone with PSAP
5) Follow-up to the automated vehicle development, especially the investments being made by government into this area of technology. Integration with emergency vehicles
6) Community paramedics data collection. The need for a standardized data set
7) Data Manager standardized training
8) Development of mechanisms to analyze data in ways to produce positive outcomes
9) Assessment of the status of all previous Advisories

Profession Safety: (Matthew Powers & Bret Garrett)

1) Use of emergency lights and sirens. Review of literature and development of recommendations based on risk/benefit analysis to reduce emergency vehicle accidents and injuries, while improving response
2) Air-to-ground EMS patient transfer issues, especially stretcher to stretcher (when stretchers are incompatible with mode of transportation)

Preparedness & Education: (Nanfi Lubogo & Mary Ahlers)

1) 911 call taker educational standards for EMS, including focus on rural and pediatric dispatch procedures addressing the lack of state mandates for minimal EMD training and certification
2) Advisory related to educators/instructors for standardized qualifications or certification

Equitably Patient Care: (Richard Bradley & Chuck O'Neal)

1) Social determinants of health and the use of EMS services. Relationship to EMS's evolving public health mission (expansion of Community Paramedicine and scope-of-practice)
2) Leveraging NEMSIS data (perhaps expanding the data elements) to assist in assessing the inequities of EMS care provided to patients based on demographics, socioeconomic status, etc.
3) Expanding EMS practitioners' performance of care to include detailed observation of a patient's circumstances to inform the impact of their situation on their health (food insecurity, filthy environment, homelessness, abusive environment, etc.). How to gather information and to whom will it be transferred. The proper segment of social and health

support services to follow-up. Including linkage to hospital case management & discharge services
4) Reassess/Update the EMS Research Agenda for the Future
5) The effect of increasing obesity on patients' ability to attain healthcare, especially the implication of increasing use of EMS to assist their physical movement
6) Recruitment & Retention of minorities to help balance inequities in patient care

Sustainability & Efficiency: (Shawn Baird & Jonathan Washko)

1) Financial sustainability during a sustained, protracted, wide-spread disaster that adversely affects EMS organizations (volume sensitivity of EMS) and the ready availability of relief funds
2) Include PSAPs and 911 call centers in disaster support funding (e.g. staffing shortages and PPE for workplace safety)
3) Dispatch centers' integration into the developing healthcare-oriented paradigm associated with the expansion of EMS services into public health
4) Cost reporting related to CMS and efficacy of data elements collected
5) Creation of a "dashboard" of real-time financial stress questions for EMS agencies, particularly focused on sustainability during major disasters

Adaptability & Innovation: (Val Gale & Lori Knight)

1) Standardized risk/benefit analysis guides for EMS Agencies to review when considering new medical technology
2) Recruitment; expanding in-school marketing of EMS as a career
3) Support for rural areas to advertise EMS as a career
4) Definitions from CMS on cost reporting and reimbursement
5) Telehealth expansion to include audio only
6) New normal for procedures for supplies & equipment; Crisis standards for disinfections, triage, hospital destinations, staffing shortages & crew complements, changes in transport regimens, etc. new tech & methodologies for efficiency
7) New public education campaign or public service announcement on the value of EMS
8) Work toward resolving the social inequities in health care through the recruitment and retention of minorities